

Case Number:	CM15-0125208		
Date Assigned:	07/09/2015	Date of Injury:	06/12/2012
Decision Date:	08/05/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	06/29/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Neurological Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 51 year old female patient who sustained an industrial injury on 06/12/2012. The accident was described as while working she had someone in a wheelchair run over her foot. Previous diagnostic testing to involve: electrodiagnostic nerve conduction study, magnetic resonance imaging of lumbar spine. A recent primary treating office visit dated 02/13/2015 reported the patient with subjective complaint of having back pain that radiates down the low back down bilateral lower legs; lower backache and left foot pain. The pain is rated an 8 in intensity out of 10 with the use of mediations and a 10 in intensity without medications. She states the efficacy of the pain medications is less now. Her activity level remains unchanged. Current medications are: Celebrex, Celexa, Tizanidine, Butrans, Cymbalta, Oxycodone, and Motrin. The following diagnoses were applied: lumbar radiculopathy, foot pain, and sacroiliac pain. The plan of care noted the patient with recommendation to utilize a walker with ambulation secondary to having continued weakness in the legs. She is to follow up with urology as needed. A CURES report noted with findings consistent with prescribed medications. She uses a transcutaneous nerve stimulator unit, a rotator walker and is requesting a shower chair as she currently is using a cane against medical advice. Discontinued medications consist of: Percocet 5/325mg, Lyrica, Naprosyn, Lexapro, Norco 5/325mg, Neurontin, Amitriptyline and Baclofen. The patient is found to be permanent and stationary as of 03/14/2014.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

L4-L5 transforaminal lumbar fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not provide this evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: L4-L5 transforaminal lumbar fusion is not medically necessary and appropriate.

3 day inpatient stay: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Assistant surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-operative lumbar brace: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.